Gendering in infant feeding discourses: The good mother and the absent father

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Abstract

Contemporary breastfeeding discourses in Aotearoa/New Zealand – encapsulated in the 'breast is best' slogan – have emerged from a convergence of feminist and medical discourses. However, these discourses have developed in ways that limit the ways in which women care for their infants if they wish to be understood as 'good mothers'. In this article, I demonstrate how these ideologies appear to inform material intended for new parents and health workers in Aotearoa/New Zealand, while simultaneously working to exclude fathers from both decision-making and involvement in much of the care of new-born infants. Current policy also constrains the ways in which health workers may provide new parents with information about formula feeding. I suggest that, in this context, neither the feminist nor medical goals that originally informed contemporary breastfeeding discourses are being effectively realised.

Introduction

The current discourses that exist around breastfeeding in Aotearoa/New Zealand– best summarised as 'breast is best' – can be understood to exist at a convergence of feminist aspirations to demedicalise childbirth and allow women to regain control over their own pregnancies and birth (Blum, 1993; Frost, Pope, Liebling, and Murphy, 2006; Rudolfsdottir, 2000; Ryan and Grace, 2001), and more medically-oriented attempts to change practices of infant feeding in third world contexts (Wall, 2001; Wallace and Chason, 2007). While both these goals are certainly worthy, here I argue that they have become inflected in particular ways, resulting in a situation in which the definition of the 'good parent' is gendered in specific, and limiting, ways for both men and women. Most notably, ideals of women having 'choice' in areas such as infant feeding are problematic, while men are often excluded from particular areas of early parenting.

This paper initially emerged from my own problematic experiences of breastfeeding my first (and only) child.[1] Building on this experience, I explore how these contemporary discourses both inform, and are reinforced by, various policy-related texts in Aotearoa/New Zealand and distributed to parents and health professionals. I suggest that these discourses work to maintain parenting as an activity that remains gendered in very particular, and largely unquestioned, ways. This argument draws on a small but growing literature that examines how

[1] I use the term 'breastfeeding' to refer to feeding breast milk via the breast. 'Formula feeding' is used to refer to feeding formula via a bottle. Where I discuss instances of expressed breast milk being delivered via bottle, this is explicitly explained.

contemporary breastfeeding discourses work to construct mothering in particular ways (Avishai, 2007; Knaak, 2005; Kukla, 2006; Law, 2000; Murphy, 1999, 2000; Wall, 2001). However, I also suggest that these discourses also work to maintain the absence of fathers from the realm of infant care.[2] Drawing on theorising around the 'new public health' (Petersen and Lupton, 1996), I suggest that contemporary breastfeeding discourses work to position mothers of new babies as both rational actors and nurturers who, given the appropriate information, should always make the 'right' choices to protect their baby's health and wellbeing, while simultaneously excluding fathers from either the responsibility or rewards of caring for these babies.[3]

It is important to be clear that I am not, in any way, *anti*-breastfeeding, primarily because I do not see breastfeeding and bottle-feeding as being mutually exclusive in terms of whether one might support one or the other. Thus, I might position myself as *pro*-formula-feeding, while at the same time actively supporting the right of parents to choose breastfeeding for their infants, their right to be informed and supported in this choice, and the rights of women to breastfeed whenever and wherever they choose without incurring public censure.

The personal problem

Reluctant though I am to risk discrediting my ability to write on this subject 'objectively', or to suggest that my own narrative of infant feeding is representative, it would be disingenuous to deny the links between my work in this area and my experience of infant feeding. My first child, Eli, was born in 2005. My partner, Hitendra,[4] and I worked together to ensure that Eli's well-being while in-utero was optimised, and intended to exclusively breast-feed for the first six months of Eli's life. However, following a difficult birth, my initial attempts at breastfeeding were far from successful, and after three days at the post-birth care facility, Eli was given some formula (after I signed a form stating that I had expressly consented to this.)

Ongoing health problems meant that after we returned home, Eli was given a combination of breast milk (both breastfed and bottle-fed) and formula. Breastfeeding was often painful for me, Eli would only open his mouth wide enough to successfully latch on when

[2] I am aware that my focus on 'the father' potentially excludes situations in which infants are not primarily cared for by couples, or by heterosexual couples, or by any person other than the infant's biological parents. However, part of the purpose of this paper is to highlight how contemporary breastfeeding discourses work to sustain particularly gendered contexts in terms of parenting. The gendering of this discourse is most notable when referring to heterosexual couples parenting children. It is beyond the scope of this paper to adequately address related, but different, issues for sole mothers, gay and lesbian parents, and other parenting units.

[3] I would like to thank Denise Mildon for brining to my attention Petersen and Lupton's (1996) critiques of the new public health ideologies, and their usefulness in understanding contemporary breastfeeding discourses.

[4] Hitendra and I have agreed that it makes little sense to use pseudonyms in talking about the experiences of our family.

he was crying, and there was only one only chair in the house in which I could successfully feed. There were moments when breastfeeding did work, and I vividly recall the pleasure and pride I took from nourishing our baby. However, these moments were so rare as to be remembered as 'triumphs'. As a general rule, breastfeeding was something that distanced me from a body that refused to do what I wanted it to, a body that became treated by myself and others as a malfunctioning mechanism. After six weeks, and with Hitendra's agreement, I ceased breastfeeding altogether. The relief I felt on making this decision was not just a result of the physical pain ending, but of regaining my body and some small part of my life, both of which I felt had been almost completely sacrificed to the care of my child since his birth, a feeling that ambivalently co-existed with my feelings of pleasure during moments of successful breastfeeding.

Even while Eli was ostensibly 'breastfed', Hitendra bottle fed him expressed breast milk much of the time, and the cessation of breastfeeding meant that feeding Eli could be completely shared, both in terms of labour and enjoyment. While my problematic experience of breastfeeding has been the genesis of my interest in this area, it is equally the manner in which formula feeding facilitated the commitment on both our parts to truly joint parenting that has led to my critiquing of the gendering of the infant feeding process.

I attribute the difficulties I had with breast feeding to a number of things, including my illness, the difficulty Eli seemed to have with latching on successfully, and some early medical mismanagement. However, it certainly was not a result of lack of perseverance on the part of either Hitendra or myself, even though it affected us both physically, emotionally, and financially. When we chose to stop, I remained guilty about this decision for some time, and regularly wondered if maybe I should 'give it one more go'. However, I didn't, and as I write Eli is now a bright, healthy three-year-old who, as far as Hitendra and I can ascertain, is equally attached to both his parents.

I offer this brief narrative not to present myself as any kind of martyr, nor my partner as any kind of hero, but rather to highlight a situation even 'well intentioned' parents found themselves in when attempting to make what we understood to be the 'right' choice regarding our baby's wellbeing. In spite of the considerable difficulties we faced, only one of the numerous health workers we encountered suggested that we might think about giving up breastfeeding, and no one offered exclusive formula feeding as a possible option. We were, however, provided with considerable support in our efforts to maintain breastfeeding, even when it seemed so clearly detrimental to my well-being, and to the maintenance of 'healthy' relationships within our family. Part of my project in this paper is to explore the constraints placed on health workers in terms of the advice they can offer new parents about infant feeding.

These experiences, and the follow-on effects of having Hitendra so integrally involved in Eli's early care, have led to an interest in the ways in which parents – both mothers and fathers – are located with contemporary infant-feeding discourses. The more significant expressions of these discourses in Aotearoa/New Zealand is the material that is made available to first-time parents, and the policy which informs the practices of the health workers who advise and assist them. In the literatures for both parents and health workers, which are largely written and provided by the Ministry of Health (MOH),[5] discursive practices work to both reflect and maintain specific ideologies of the appropriate gendering of infant care-giving. This has two primary effects – women are expected to conform to particular ideals if they wish to be understood as 'good mothers'; and fathers are virtually excluded from any decision making or actions that involve infant feeding.

In this paper I analyse a range of policy documents authored by the MOH (Ministry of Health, 2002, 2004c, 2007), various publications published by MOH and others intended for new parents (Ministry of Health, 2004a, 2004b, 2006; Ministry of Health, Well Child, and Royal New Zealand Plunket Society (Inc.), 2005), and a 2007 report commissioned by MOH (Thornley, Waa, and Ball, 2007). I focus on these texts because they comprise the material that best represents the dominant ideologies of the central state agency responsible for monitoring the actions of health workers and distributing information to new parents in Aotearoa/New Zealand.

The policies and their context

Current policy in Aotearoa/New Zealand around the role health workers play in advising parents on infant feeding closely follows the World Health Organisation's 1981 *International Code of Marketing of Breast-Milk Substitutes*. Health workers are advised to "protect, promote and support breastfeeding" (Ministry of Health, 2007). Yet there is no working definition of what this actually means, especially in terms of how this relates to formula feeding. While health workers are advised to enable parents to make informed decisions regarding infant feeding, breastfeeding is clearly assumed to be the 'right' outcome of this decision. The instruction to health workers to guide feeding practices "by encouraging and facilitating breastfeeding and providing objective and consistent advice to mothers and families about the superior value of breastfeeding" (Ministry of Health, 2007) is entirely typical in this regard – the contradiction of providing 'objective' advice while simultaneously presenting breastfeeding

[5] MOH is responsible for the health and disability system in NZ, and is the government's primary advisor on health policy. They are also the government agency responsible for implementing and monitoring the International Code of Marketing of Breast-milk Substitutes in Aotearoa/New Zealand.

as 'superior' seems to go unnoticed, and the fact that breastfeeding may not always be the 'superior' choice for all concerned is not considered. Similarly, in material intended for parents, breast milk is consistently described as "the perfect food for your baby … [that] changes with your baby's needs … helps protect your baby against infection … lower risks of allergies … [and is] cheap, safe, environmentally friendly and ready to use!" (Royal New Zealand Plunket Society (Inc.) and Bounty Services Ltd., 2005), while the sparse advice offered to those considering using formula regularly includes suggestions to "think about the ongoing expense of formula and equipment, as this will affect your family budget" (Royal New Zealand Plunket Society (Inc.) and Bounty Services Ltd., 2005).[6]

It seems reasonable to assume that MOH and related bodies are primarily promoting breastfeeding on the basis of its beneficial contribution to the health of infants. This is communicated to parents in the advice that breast milk is "the perfect food for baby" (Royal New Zealand Plunket Society (Inc.) and Bounty Services Ltd., 2005). While formula is not explicitly described as being unhealthy, it occupies the position of the absent 'other' in an implicit best-worst dichotomy (Knaak, 2005; Kukla, 2006; Murphy, 1999). The continued reiteration of statements about the 'benefits' of breastfeeding (e.g. resistance to illness, cognitive development, or risk of conditions such as diabetes and obesity) imbues them a level of veracity that remains unquestioned (Law, 2000). Even when language such as 'associated with' and 'may' is used to indicate the provisional nature of these statements (Ministry of Health, 2008), constant reiteration works to embed these apparent associations as 'truth' in the prevalent discourses. In the local context, this is grounded in the linking of Aotearoa/New Zealand's infant feeding policies with those of WHO (Ministry of Health, 2004), an institution with considerable credibility. What is less regularly mentioned is the fact that WHO's Code was primarily established in reaction to the marketing and use of formula in third world countries (Palmer, 1993), and that for babies fed formula in contemporary western contexts, virtually none of the same risks exist (Kukla, 2006) – or if they do, they would be prevented if health professionals consistently educated parents about appropriate practices when feeding babies formula (Kent, 2006).[7]

The apparent benefits of breast-feeding are similarly reiterated to such an extent that they take on the status of unquestionable 'fact'. At the time of writing, the most recent MOH publication relating to breastfeeding provided the standard list of benefits for infant: optimum

[6] In this paper, I do not explicitly consider how wider social contexts, particularly those related to economic concerns, impact on the 'choices' parents make around infant feeding. It is, however, worth noting here that a family's budget might also be affected by the difficulties a breastfeeding mother has with undertaking paid employment.

[7] See Law (2000) for a sustained discussion of the virtual absence of the third world specificity of most risks associated with formula feeding in contemporary breastfeeding information.

nutrition; benefits in relation to physical and emotion development; decreasing incidence and severity of infectious diseases; decreasing infant mortality and hospitalisation; decreasing risk of chronic disease (Ministry of Health, 2008). While breastfeeding undoubtedly does have a range of potential health benefits, the actual rates of differences of measures between breastfed and formula fed infants are virtually never provided. A meta-analysis of the breastfeeding research (Ip et al., 2007) suggests that actual levels of reduction of various adverse health outcomes varies considerably. Furthermore, in many of the health benefits cited in breastfeeding discourses, the actual risk associated with the specific problem may not be particularly significant to begin with. For example, breastfeeding is associated with a 72% reduction in hospitalisation from lower respiratory tract diseases (Ip et al., 2007). However, as only 3% of infants in the general population are hospitalised from lower respiratory tract diseases, the reduction is real terms is relatively small – from a 3% risk to maybe around 1%. In a second example, breastfeeding is also commonly associated with lower risks of gastrointestinal infections, the rather of which are high at 110% in under-five-year-olds (i.e. 1.1 incident per person-year). Breastfeeding does appear to reduce this by 64% (Ip et al., 2007). However, two points bear mention here. First, it seems likely that equipping formula feeding parents to engage in adequate hygiene practices could lower this rate among formula fed babies. Second, I would suggest that gastrointestinal infections, while not pleasant, and occasionally dangerous, are fairly common among the wider population as a whole, and in many instances would be self-diagnosed as the less-ominous 'tummy bug'. Obviously, in both instances it would be preferable that rates were lower, particularly among vulnerable infants, and I am not arguing that there is any 'acceptable' level of ill health among babies. Rather, I am suggesting that parents should be informed about these issues in ways that allow them to weigh up the *actual* severity of health risks against the many other factors they must take into account when making decisions about infant feeding.

However, in the current context MOH *appears* to provide scientific information (i.e. the lists of benefits of breastfeeding and risks of formula feeding) so as to allow parents make 'informed' choices about infant feeding, but does so in such a way that only one option is really 'rational', and is hence the choice that the good modern parent is expected to make. Contemporary breastfeeding discourses at the state level can thus be situated as part of the new public health model, which encompasses neo-liberal ideals of individual informed choice, while also creating contexts in which only specific choices (i.e. those that benefit the state by reducing health costs with minimal government spending) seem reasonable.

The good mother

To some extent, any real measures of the benefits of breastfeeding would be redundant in the contemporary context (Knaak, 2005), in which parenting is constructed as a process in which the well-being of the baby is *always* prioritised above the interests of any other involved party (Avishai, 2007). Women are particularly affected by this ideology, even before their children are born, as 'fetal rights' discourses charge pregnant women with ever-increasing responsibility over the health of their foetuses, while the women themselves are reduced to an 'environment' in which the unborn child grows (Kukla, 2006; Pollitt, 1998; Rudolfsdottir, 2000). This can be seen as a consequence of women's historical positioning as the caretakers of the health of their families, reproducing (rather than *being*) the ideal healthy citizen (Petersen and Lupton, 1996).[8] The concern pregnant women are expected to have for their foetuses can also be linked to the ways understandings of the optimum way to raise children in western cultures shifted in the middle of the 20th century so that the child's interests "took the forefront, and good mothering involved anticipating and adapting to children's requirements" (Wall, 2005; see also Knaak, 2005).

This ideology is consequently drawn on to encourage women to breastfeed, evident in statements such as "breastfeeding is associated with being a good mother" (Thornley, Waa, and Ball, 2007), while feeding one's baby formula positions one as the unspoken 'other' to the 'good mother'. Of course, the formula feeding parent is never *explicitly* represented as the 'bad mother', but this is implicit in all the exhortations to maintain breastfeeding, even in the face of the many difficulties which are regularly mentioned – as formula feeding is never presented as a means of either avoiding or solving these problems, the woman who chooses this option ceases to engage in one of the acts that defines the 'good mother'. Critiques of the links between breastfeeding and the contemporary construction of the 'good mother' are well-developed in the relevant literature, and I will not reiterate them here. Rather, I will explore how, in spite of the pressure this discourse places on many women, it continues to form the basis of most infant feeding advice in contemporary Aotearoa/New Zealand.

The 'naturally' good mother

One of the means by which women are encouraged to initiate and maintain breastfeeding is via references to this being 'natural'. In the research undertaken to inform MOH's upcoming breastfeeding campaign, among the key messages to be used are that "breastfeeding is natural and normal" and "most women breastfeed" (Thornley, Waa, and Ball, 2007), while the MOH

[8] As Pollitt (1998) notes, this allows the state to appear to be protecting unborn children by controlling the actions of pregnant women, while simultaneously incurring little cost to themselves. Similarly, breastfeeding campaigns allow the state to again to be seen to protecting the interests of infants, while providing little in the way of actual resources to families with breastfeeding infants.

publication most recent at the time of writing states that breastfeeding is "the biological norm for infant feeding and is a traditional practice in most cultures" (Ministry of Health, 2008). While breastfeeding is understood as 'natural' and thus linked to the apparent universality of breastfeeding historically and culturally, the material reviewed does note that some women find it more difficult than others. However, women experiencing the pain, exhaustion, or infections commonly linked to problematic breastfeeding are simply reassured that it will become easier. Underlying these reassurances is the understanding that breastfeeding is something 'all women' are capable of. This overlooks the fact that, in the vast majority of contexts, there has not been any other truly viable alternative for infant nourishment. Furthermore, while most babies have historically and across cultures been breastfed, this is not to say that they have all, or always, been breastfed by their biological mothers. The rise and decline of wet-nursing has been relatively well documented (Golden, 1996). Less visible is the practice of cross-nursing, where a woman feeds the child of a friend or acquaintance. Cross-nursing continues to occur in contemporary western societies (Krantz and Kupper, 1981; Long, 2003; Shaw, 2007), but provokes ambivalence and even repulsion amongst some mothers (Long, 2003; Shaw, 2004), and there are very real concerns around cross-nursing in terms of the potential for viral transmission. Thus, suggesting cross-nursing as a means of maintaining breastfeeding in contemporary Aotearoa/New Zealand may not be viable. However, the silence around this activity means that statements about the 'universality' of breastfeeding are potentially misleading, and may create unrealistic standards for contemporary mothers.

The nourishing mother

Clearly, many women do find breastfeeding hugely rewarding. However, I do not believe that I am alone in feeling resentment at being solely responsible for the nourishment of this small, helpless being, which I also loved. But giving voice to this ambivalence threatens one's status as a 'good' mother, and challenges the moral core of motherhood, that the child always takes priority (Murphy, 1999; Schmeid and Lupton, 2001). It also brings into question the 'bonding' process that is currently constructed as fundamental to a successful mother-child relationship.

In almost all the policy and parental material examined here, bonding is not explicitly referred to, possibly in recognition of the lack of science around bonding as either a physiological or psychological 'fact' (Arney, 1980; Crouch and Manderson, 1995). However, in the most recent MOH publication, ostensibly related to nutritional guidelines for babies and infants, it is suggested that "the natural bonding between mother and infant may also be enhanced by breastfeeding" (Ministry of Health, 2008). Furthermore, while 'bonding' is not (yet) explicitly referred to in the publications intended for parents, it does remain prevalent in everyday discourse, and is thus easily referenced with statements such as "breastfeeding

provides a means for you and your baby to get to know each other" (Royal New Zealand Plunket Society (Inc.) and Bounty Services Ltd., 2005).

There is little doubt that babies who have regular and affectionate physical contact are healthier and happier, and feeding is one of the primary processes through which an emotional attachment develops between infant and caregiver. However, the physical contact maintained during breastfeeding can also be easily achieved during formula feeding. Yet current advice provided on formula feeding tends to only functional – I was only able to locate one brief mention of how to promote affection while formula feeding (Ministry of Health, Well Child, and Royal New Zealand Plunket Society (Inc.), 2005), while the connection promoted through breastfeeding is almost invariably discussed. This scarcity of suggestions that formula feeding can be a process imbued with physical contact and affection contributes to the continual down-grading of formula feeding, and its positioning as the decision of a 'bad mother' who does not care for her child.

Introducing the father

Eliding the possibilities of formula feeding as an affectionate and caring activity also works to render invisible one of the key potential benefits of formula feeding, that one of the central acts of infant nurturing can now be undertaken by people other than the mother – most significantly, by the baby's father. This is but one of the spaces that fathers could occupy in infant feeding discourses if these discourses were not so thoroughly colonised by breastfeeding. The implication of this focus on breastfeeding seems to be that all decisions regarding infant feeding are the domain of the mother. While much of the policy documentation refers to the need to include 'family and whanau' in breastfeeding advocacy, little mention is made of the father in terms of decisions making, and education and advocacy is almost exclusively directed at the mother. This is in spite of the fact that a significant amount of research suggests that the father's support and positive attitude is one of the most significant factors in initiating and sustaining breastfeeding (Arora, McJunkin, Wehrer, and Kuhn, 2000; Dennis, 2002; Freed, Fraley, and Schanler, 1992; Giugliani, Caiaffa, Vogelhut, Witter, and Perman, 1994; Kessler, Gielen, Diener-West, and Paige, 1995; Littmann, Medendrop, and Godfarb, 1994; Scott, Binns, and Aroni, 1997; Scott, Landers, Hughes, and Binns, 2001; Sharma and Petosa, 1997; Shepherd, Power, and Carter, 2000; Wolfberg et al., 2004). However, this literature continues to position infant feeding decisions as both the right and responsibility of the mother – almost without exception, these authors talk about how the father *influences the mother's decision*, rather than suggesting that he is part of the decision making process. Coming from a largely medical perspective, this empirical research thus presents any paternal influence that leads to

breastfeeding as positive, while any that leads to formula feeding is implied to be misguided, selfish, and ultimately negative, while a more sociological approach suggests that women who choose to formula feed so as to satisfy their partner's desire to be involved in the infant's care are assuming responsibility for men bonding with their babies (Murphy, 1999).

Yet emerging research suggests that some men, who find the new ideal of the 'involved father' an attractive and worthy role, do feel that breastfeeding impacts on their relationships with their new babies (Anderson, 1996; Barclay and Lupton, 1999; Goodman, 2004; Jordan and Wall, 1990), and Gamble and Morse specifically outline how the fathers of breastfed infants find it necessary to postpone real involvement with their infants (1992). While the fathers in Gamble and Morse's research believed that they would 'catch up' in terms of forming strong connections with their children, I would suggest that this could be difficult, as breastfeeding tends to 'naturally' lead on to range of behaviours that increase the strength of the mother-child relationship. Breastfeeding women often sleep with their infants (and not their partners) so as to feed during the night with minimal disruption; breastfeeding means that the mother cannot be away from the infant for extended periods of time; and breastfeeding means it is more logical for the mother to adjust her employment commitments to care for the new-born infant, which often leads on to continuing to be primary caregiver. Working against these factors so that the child develops an equally deep relationship with their father would require considerable commitment on the part of both parents. One of the most significant benefits of formula feeding for us, and for other parents I have spoken with, has been the more complete inclusion of fathers in the care of the infant. Yet material that is provided to parents on infant feeding predominantly presents activities around infant feeding, and related care, as the mother's domain.

The gender specificity of the 'ideal' infant feeding relationship is most explicit in the latest MOH publication, in which it is stated that breastfeeding "encourages emotional attachment between the mother and infant" (Ministry of Health, 2008), while the possibility for formula feeding to do same for the father and infant is not mentioned – in fact, in all mentions of formula feeding, the father remains notably invisible. This absence is particularly notable in the *Feeding Your Baby Infant Formula* pamphlet (Ministry of Health, Well Child, and Royal New Zealand Plunket Society (Inc.), 2005). Only two images are shown of people bottle feeding their babies, both of whom are women. Although removing the breast from the feeding process means that infant feeding can be a totally gender-neutral activity, this is visually presented as being solely the domain of the mother. Similarly, any mention of talking about issues relating to formula feeding is framed as discussions that would take place between the mother and a health practitioner. The father is rarely, if ever, positioned as part of the decision-

making process, and is never represented as a parent who might also feed the child. Any specific mention of fathers is more often negative. For example, research is cited which shows that "women whose partners expressed a definite preference for breastfeeding were 10 times more likely to initiate breastfeeding than those whose partners either preferred bottle-feeding or were ensure about breastfeeding" (Ministry of Health, 2002).

I should note here that some women I spoke with while developing this paper suggested that, because of the embodied nature of breastfeeding, it was a decision they felt *was* their right to make alone. In light of this, it is possible that my perspective on this issue may be peculiar to my own experience. I am currently engaged in empirical research with new parents in which I will address this issue – the goal of this research is to ascertain how both mothers and fathers understand the processes of making decisions about infant feeding, and how the decisions they make impact on the roles they take in caring for their infants.

Conclusion

Lest my purpose in this paper be misunderstood, I am not arguing here for disembodying infant feeding practices, nor suggesting that women's bodies should behave more like men's when engaging in activities such as feeding infants in public places (Hausman, 2004). Furthermore, I recognise that breastfeeding entails an embodied activity that is particular to women (Hausman, 2004), and entails a corporeality that many women take great pleasure in. However, I would suggest that infant nurturing is an act that, should parents so choose, can also be performed by the father, with minimal risk to the infant, and that this may well serve to relieve some of the constraints that some mothers feel on an individual level, and that women in general feel in terms of exhortations to be 'good mothers'. Breastfeeding was not the action through which I 'performed maternity' in any embodied sense (Bartlett, 2000) – in fact, my attempts to maintain breastfeeding (or at least the delivery of breastmilk to Eli) meant that I was often physically distant from my baby, and in a state of exhaustion that was so overwhelming as to severely compromise our relationship. It was only once I stopped breastfeeding that I could truly enjoy Eli both emotionally and physically. While this was primarily a result of health-related issues that are, admittedly, not common (although more common than the MOH material suggests), the consequence was that the pleasure of nurturing our child could now be fully shared by Hitendra, and our subsequent experiences of truly shared parenting, and Eli's relationship with the both of us, suggest that this is not a factor that should be taken lightly when making decisions around infant-feeding.

Recommendations at the time of writing regarding a planned new breastfeeding campaign are strongly in favour of maintaining the 'breast is best' message (Thornley, Waa,

and Ball, 2007). This is in spite of the fact that a decade of this message seems to have had a minimal effect on breastfeeding rates in Aotearoa/New Zealand (Chadwick, 2008; Ministry of Health 2002b; 2008). International research suggests that expectant and new mothers are, in fact, well aware of the potential health benefits of breastfeeding for their babies (Earle, 2002; Zimmerman and Guttman, 2001). Given that considerable public expenditure on promoting this message seems to be doing so little to increase breastfeeding rates, it may be advisable to consider alternative approaches to informing parents about infant feeding, approaches that would not replace the 'breast is best' message, but rather supplement it with an additional 'but not the *only* option' clause. Such an approach could ameliorate many of the spoken and unspoken concerns around formula feeding by educating parents to formula feed in ways that minimise potential risks, and working to minimise the feelings women who do not breastfeed have that they have failed their babies. Such an approach could also take the opportunity offered by formula feeding to devolve responsibility for infant care to both parents.

I would suggest that this potential restructuring of the parenting of new-born infants may then lead to this activity being something that both parents wish to be involved in – in much the same way as both parents may also want to be involved in paid employment – and thus lead to the increased valuing of parenting as a social role. I would, however, reiterate that this should not be at the cost of breastfeeding – but rather, that given the apparent plateauing of rates of breastfeeding, it may be time to rethink what this means, and how this might be addressed so as to gain the most benefit from the situation for mothers, fathers, and infants.

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